

1 TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 12 hours after death. The bottom copy may be retained by the hospital or attending physician.

2 TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

01902
Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Charles</i>		MARYLAND		STATE <i>Md</i>		COUNTY <i>Charta</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>Monkbury</i>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Monkbury</i>		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <i>Essie</i> (Middle) (Last) <i>Berry</i>				(Month) <i>Feb.</i> (Day) <i>5</i> (Year) <i>1958</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>Col.</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Single</i>	8. DATE OF BIRTH <i>6-10-99</i>	9. AGE last birthday <i>58</i> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housework</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Chicommuxen, Old</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Joseph Berry</i>				14. MOTHER'S MAIDEN NAME <i>Lizzie Orlestead</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <i>Washington DC Goldie Davis 1479 Bangor St. N.W.</i>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
431x IMMEDIATE CAUSE (A) <i>Acute Myocarditis</i>				INTERVAL BETWEEN ONSET AND DEATH <i>1 wk.</i>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Generalized Arthritis</i>				15 yrs			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>1/30</i> , 19 <i>58</i> , to <i>2/5</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>2/4</i> , 19 <i>58</i> , and that death occurred at <i>10 P</i> M, from the causes and on the date stated above.							
SIGNATURE <i>Frank G. Luman</i>				ADDRESS (Street, city, town, state) <i>Indian Head, Md</i> DATE SIGNED <i>2/5/58</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>2-9-58</i>		DATE THEREOF <i>Burial</i>		NAME OF CEMETERY OR CREMATORY <i>Alexander M.E. Church</i>		LOCATION (City, town, or county) <i>Chicommuxen Old</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>DeLoach</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Johnson and TenKins</i>		ADDRESS <i>N.W. 4804 Georgia Ave.</i>	
DATE <i>FEB 10 '58</i>							

CERTIFICATE OF DEATH

1. DECEASED'S NAME (Print or Type)

2. SEX

3. AGE

4. RACE

5. BIRTH DATE

6. BIRTH PLACE

7. DEATH DATE

8. DEATH PLACE

9. CAUSE OF DEATH

10. MANNER OF DEATH

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF DEATH REGISTRAR

13. SIGNATURE OF WITNESS

14. SIGNATURE OF CORONER

15. SIGNATURE OF JURY

16. SIGNATURE OF JUDGE

17. SIGNATURE OF CLERK

18. SIGNATURE OF SHERIFF

19. SIGNATURE OF TOWNSHIP CLERK

20. SIGNATURE OF COUNTY CLERK

21. SIGNATURE OF STATE CLERK

22. SIGNATURE OF U.S. MARSHAL

23. SIGNATURE OF U.S. ATTORNEY

24. SIGNATURE OF U.S. DISTRICT JUDGE

25. SIGNATURE OF U.S. SUPREME COURT

26. SIGNATURE OF U.S. SENATE

27. SIGNATURE OF U.S. HOUSE OF REPRESENTATIVES

28. SIGNATURE OF U.S. DEPARTMENT OF JUSTICE

29. SIGNATURE OF U.S. DEPARTMENT OF STATE

30. SIGNATURE OF U.S. DEPARTMENT OF COMMERCE

31. SIGNATURE OF U.S. DEPARTMENT OF AGRICULTURE

32. SIGNATURE OF U.S. DEPARTMENT OF INTERIOR

33. SIGNATURE OF U.S. DEPARTMENT OF LABOR

34. SIGNATURE OF U.S. DEPARTMENT OF EDUCATION

35. SIGNATURE OF U.S. DEPARTMENT OF HEALTH

BUREAU V. S.

FEB 10 1958

RECEIVED

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1910

CERTIFICATE OF DEATH

Reg. Dist. No.

01903

1. PLACE OF DEATH a. COUNTY Charles MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bryantown				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Madeline Middle Turner Last Burroughs				4. DATE OF DEATH Month Feb Day 10 Year 19 58			
5. SEX Female	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 10, 1876	9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Duncan M. Turner				14. MOTHER'S MAIDEN NAME Rose Maddox			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -		17. INFORMANT Mrs Ben Edelen Bryantown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral & thrombosis 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic C.V. disease DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 30 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma breast (excised 1952) - local recurrence							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1948 to Feb 10, 1958 , that I last saw the deceased alive on Feb 10, 1958 , and that death occurred at 8:30 M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Mechanicsville, Md DATE SIGNED							
ACTUAL SIGNATURE Ray E. Luytner M.D.				PHYSICIAN'S NAME (Type) Mechanicsville, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-13-58		22c. NAME OF CEMETERY OR CREMATORY All Faith Cem.		22d. LOCATION (City, town, or county) (State) Charlotte Hall, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home Waldorf, Md.				24a. REC'D BY REGISTRAR DATE FEB 13 58		24b. REGISTRAR'S SIGNATURE W. H. Smith	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

REG. CIV. NO.

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

SEX

EDUCATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH OF SPOUSE

DATE OF DEATH OF DECEASED

DATE OF DEATH OF DECEASED

DATE OF DEATH OF DECEASED

DATE OF DEATH OF DECEASED

DATE OF DEATH OF DECEASED

DATE OF DEATH OF DECEASED

DATE OF DEATH OF DECEASED

BUREAU V. E.

FEB 13 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01904

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Charles</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Faulkner md.</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <i>Faulkner md</i>	
3. NAME OF DECEASED (Type or print) <i>Elizabeth Agnes Butler</i>		4. DATE OF DEATH <i>Feb 6</i> 19 <i>58</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Col</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 29 1869</i>
9. AGE (In years last birthday) <i>88</i> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>	
11. BIRTHPLACE (State or foreign country) <i>Charles Co</i>		12. CITIZEN OF WHAT COUNTRY? <i>no d.o.</i>	
13. FATHER'S NAME <i>Med Proctor</i>		14. MOTHER'S MAIDEN NAME <i>Sally Ann Thompson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>William B Butler</i>		Address <i>Bethesda md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Sen Visceral Atrophy</i> 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>See but see</i> (c)		INTERVAL BETWEEN ONSET AND DEATH <i>2-6-58</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>E. J. Edelen</i> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>E. J. EDELEN</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>2-10-58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>St Thomas</i>	22d. LOCATION (City, town, or county) (State) <i>Chapel Point md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Archard Mc Saplata md.</i>		24a. REC'D BY REGISTRAR <i>Feb 11 '58</i>	
		24b. REGISTRAR'S SIGNATURE <i>Archard</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED: _____
AGE: _____ SEX: _____
DATE OF DEATH: _____
PLACE OF DEATH: _____

1. CAUSE OF DEATH: _____
2. MANNER OF DEATH: _____
3. DISEASES PREEXISTING AT THE TIME OF DEATH: _____
4. MEDICAL HISTORY: _____
5. SOCIAL HISTORY: _____
6. OCCUPATION: _____
7. EDUCATION: _____
8. RELIGION: _____
9. MARITAL STATUS: _____
10. FAMILY HISTORY: _____
11. PERSONAL HISTORY: _____
12. OTHER INFORMATION: _____

RECEIVED
FEB 11 1958
BUREAU V. R.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01905

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Charles Co</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Charles</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Welcome</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <i>1 Welcome</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>MYRTLE D. CANTER</i>		4. DATE OF DEATH <i>Feb 15 1958</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <i>Dec 30, 1905</i>	9. AGE (In years last birthday) <i>52</i> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Merchant</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Store</i>	11. BIRTHPLACE (State or foreign country) <i>St Marys Co</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>Benjamin Grove</i>		14. MOTHER'S MAIDEN NAME <i>Appelonia Davis</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Joseph E Grove Medicinesville</i>	
17. INFORMANT <i>Joseph E Grove</i>		Address <i>Medicinesville</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> 989X DUE TO <i>Multiple Blows to Cranium (Trauma)</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>5 min.</i> DUE TO <i>5 min.</i> (c) <i>5 min.</i>		INTERVAL BETWEEN ONSET AND DEATH <i>5 min.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Multiple Traumatism with blunt instrument.</i>	
20c. TIME OF INJURY Month, Day, Year <i>Ca. 9 a.m. 2-15 1958</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>		20f. (City or town) <i>Welcome, Charles, Md.</i> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>V. B. Dettor</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>V. B. DETTOR, M.D.</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>2/21/58</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Old Faith</i>		22d. LOCATION (City, town, or county) <i>Medicinesville Md</i> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur L. Laplata</i>		24a. REC'D BY REGISTRAR <i>FEB 25 '58</i> DATE	
		24b. REGISTRAR'S SIGNATURE <i>Webb</i>	

STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3

FEB 25 1933

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 1906

1913

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Welcome</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>THOMAS DESALESCANTER</u>		4. DATE OF DEATH <u>FEB 15 1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 29 1922</u>
9. AGE (In years last birthday) <u>36</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Chas Co Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Robert E. Canter</u>		14. MOTHER'S MAIDEN NAME <u>Nellie E. Hunter</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>218-12-9599</u>	
17. INFORMANT <u>Nellie E. Canter</u>		Address <u>Hughesville</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunsshot Wound of the Brain</u> 976x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Self inflicted thru forehead</u>	
20c. TIME OF INJURY Month, Day, Year <u>Feb. 9 2-15 1958</u>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
20e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20f. (City or town) (County) (State) <u>Welcome, Charles, Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>V. B. Dettor</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>V. B. DETTOR, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/21/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Burlington Mch. Burlington</u>		22d. LOCATION (City, town, or county) (State) <u>ga</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Rechart Inc Laphala Md</u>		24a. REC'D BY REGISTRAR <u>DATE FEB 5 1958</u>	
24b. REGISTRAR'S SIGNATURE <u>Dehman</u>			

MEDICAL CERTIFICATION

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18, Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

IN WYOMING STATE DEPARTMENT OF HEALTH-BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Q1000

BUREAU V. 2

FEB 25 1938

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **01907**

1. PLACE OF DEATH a. COUNTY Charles 1914 b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bryans Road c. LENGTH OF STAY IN lb 40 yrs d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Charles c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bryans Road d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle R. Last Coates		4. DATE OF DEATH Month Feb. Day 6 Year 1958	
5. SEX Male	6. COLOR OR RACE Col.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH UNK.
9. AGE (In years last birthday) 72 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Col. 10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt 11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John Coates		14. MOTHER'S MAIDEN NAME Unk	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) UNK. (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. UNK. 17. INFORMANT Joseph Washington Address Bryans Road, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Occlus in Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Heart Disease 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE Frank A. Jusen		DATE SIGNED 2-6-58	
EXAMINER'S NAME (Type) Frank A. Jusen M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-15-58	22c. NAME OF CEMETERY OR CREMATORY Mount Vernon M.E. Cem.	22d. LOCATION (City, town, or county) (State) Pomonkey, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Montt Funeral Home		24a. REC'D BY REGISTRAR DATE Feb 1 1958	
24b. REGISTRAR'S SIGNATURE		24c. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Give Page 4 to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

THOMAS A. S.

1883

1883

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, write the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be taken to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by the funeral director. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1915 Item 8 File G226 3-7-56 et											
										Reg. Dist. No. 01908	
1. PLACE OF DEATH a. COUNTY Charles MARYLAND						2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LaPlata				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Newport					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Physician's Memorial Hospital						d. STREET ADDRESS					
3. NAME OF DECEASED (Type or print) First JOSEPH Middle WILLIAM Last FARMER						4. DATE OF DEATH Month February Day 25 Year 1958					
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 4, 1914		9. AGE (in years last birthday) 44 yrs.		10. IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stenographer				10b. KIND OF BUSINESS OR INDUSTRY Chas Co Med				12. CITIZEN OF WHAT COUNTRY USA			
13. FATHER'S NAME John F Farmer						14. MOTHER'S MAIDEN NAME Mary E Cole					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT John F Farmer Address Thurport Md					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491x Confluent Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 491x DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Paul F. Guerin M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED 2/26/58		
EXAMINER'S NAME (Type) Paul F. Guerin, M.D.						ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY St Mary		22d. LOCATION (City, town, or county) (State) Newport Md			
23. FUNERAL DIRECTOR'S SIGNATURE Richard Mc LaPlata Md						24a. REC'D BY REGISTRAR Feb 26 1958		24b. REGISTRAR'S SIGNATURE Richard Mc LaPlata Md			

BUREAU V. S.

NO. 10

RECEIVED

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1916 CERTIFICATE OF DEATH

Reg. Dist. No. 01909

1. PLACE OF DEATH o. COUNTY Charles MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Alton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicians Memorial Hosp.		d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last James Francis (FRANK) Jordan		4. DATE OF DEATH Month Day Year Feb 24 19 58	
5 SEX M	6. COLOR OR RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-15-1887
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY Restaurant	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Joseph C. Jordan	
14. MOTHER'S MAIDEN NAME unk.		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO 220 16 4867		17. INFORMANT Address Elizabeth Turner Bel Alton, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Asthma</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute Posterior Myocardial Infarction</u> DUE TO (c) <u>Hypertensive Arteriosclerotic Heart Disease</u> INTERVAL BETWEEN ONSET AND DEATH 12 hours 9 days years			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypostatic Pneumonia</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) no injury		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct. 20, 1957</u> , to <u>Feb. 24, 1958</u> , that I last saw the deceased alive on <u>Feb. 24, 1958</u> , and that death occurred at <u>6:15 P. M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED V.B. DETTOR M.D. LA PLATA, MD. 2/26/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-27-58	
22c. NAME OF CEMETERY OR CREMATORY Shiloh ME Cem.		22d. LOCATION (City, town, or county) (State) Newburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home		ADDRESS Waldorf, Md.	
24a. REC'D BY REGISTRAR DATE MAR 3 '58		24b. REGISTRAR'S SIGNATURE	

BUREAU V. S.

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1917

CERTIFICATE OF DEATH

Reg. Dist. No. 01910

1. PLACE OF DEATH a. COUNTY <u>CHARLES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>CHARLES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Accokeek</u>		c. LENGTH OF STAY IN 1b <u>ROUTE 1 BOX 322</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>ROUTE 1 BOX 322</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ELSIE IRINE LITTLE</u>		4. DATE OF DEATH Month Day Year <u>FEB. 10 1958</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 25, 1910</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>45</u> yrs IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS: Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>GEORGE LUSBY</u>		14. MOTHER'S MAIDEN NAME <u>IRINE SEITZ</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>PAUL LITTLE ACCOKEEK, MD.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GENERALIZED CARCINOMATOSIS FROM</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CARCINOMA OF BREAST</u> DUE TO (c) <u>7 years</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>FEB 8</u> , 1958, to <u>FEB 10</u> , 1958, that I last saw the deceased alive on <u>FEB 8</u> , 1958, and that death occurred at <u>6:35 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R.C. Kirchner</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>6480-N. H. Ave - 2/10/58</u>	
PHYSICIAN'S NAME (Type) <u>R.C. KIRCHNER M.D.-TAKOMA PARK, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>2/12/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Suitland Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home</u>		24a. REC'D BY REGISTRAR <u>300 - 4th St. N.E. Wash D.C.</u>	24b. REGISTRAR'S SIGNATURE <u>W. H. Smith</u>

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR FUNERAL HOME: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1918

Item 1, Form 226 2-28-58 et.

CERTIFICATE OF DEATH

Reg. Dist. No. 01911

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gallant Green</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gallant Green</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				f. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>ANDREW</u> Middle <u>MIDEN</u> Last <u>MIDEN</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>16</u> Year <u>1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>CAU</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV 15, 1883</u>		9. AGE (In years last birthday) <u>74</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>?</u>	
13. FATHER'S NAME <u>UNKNOWN</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>UNK</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Friends</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Coronary Failure</u> DUE TO (b) <u>Chr. Coronary Vase. Renal Dis.</u> DUE TO (c) <u>Chr. Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>an hour</u> <u>yes</u> <u>yes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec. 1953</u> to <u>Feb 15, 1958</u> , that I last saw the deceased alive on <u>Feb 15</u> , 1958, and that death occurred at <u>9 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Vahel M. Seron</u> M.D.				ADDRESS (Street, city or town, state) <u>Aguasson, Md</u>			
PHYSICIAN'S NAME (Type) <u>VAHEL M. SERON MD</u>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Feb 22, '58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Peters</u>		22d. LOCATION (City, town, or county) (State) <u>Waldorf, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>THE HUNTT Funeral Home, Waldorf, Md</u>				24a. REC'D BY REGISTRAR <u>FEB 24 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Qu...</u>	

BUREAU V. B.

FEB 24 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1919

CERTIFICATE OF DEATH

Reg. Dist. No. 11912

1. PLACE OF DEATH a. COUNTY CHARLES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY CHARLES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHARLOTTE HALL	
c. LENGTH OF STAY IN TB 5 days		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicians Memorial Hosp.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicians Memorial Hosp.		1. d. STREET ADDRESS 1	

3. NAME OF DECEASED (Type or print) Deborah First Jean Middle MURPHY Last		4. DATE OF DEATH Month Feb Day 1 Year 1958	
5. SEX Female	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 27 Jan 58
9. AGE (In years last birthday) 5		10. IF UNDER 1 YEAR: Months 5 Days 5 Hours 5 Min. 5	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT	10b. KIND OF BUSINESS OR INDUSTRY NONE	11. BIRTHPLACE (State or foreign country) MD	12. CITIZEN OF WHAT COUNTRY? USA
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13. FATHER'S NAME THOMAS ALVIN MURPHY	14. MOTHER'S MAIDEN NAME GLADYS MARIE WATSON
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no	16. SOCIAL SECURITY NO. ---	17. INFORMANT THOMAS A. MURPHY - CHARLOTTE HALL
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory Collapse 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Prematurity DUE TO (c) 5 days		INTERVAL BETWEEN ONSET AND DEATH 3 days
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)

21. I certify that I attended the deceased from **27 Jan 58**, 19**58**, to **1 Feb 58**, that I last saw the deceased alive on **1 Feb 58**, and that death occurred at **4:50 P. M.**, from the causes and on the date stated above.

ACTUAL SIGNATURE Arthur O. Woody	M.D. LA PLATA	ADDRESS (Street, city or town, state) MARYLAND	DATE SIGNED
PHYSICIAN'S NAME (Type) ARTHUR O. WOODY			

22a. BURIAL CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 2/3/58	22c. NAME OF CEMETERY OR CREMATORY ST MARYS	22d. LOCATION (City, town, or county) NEWPORT MD
23. FUNERAL DIRECTOR'S SIGNATURE AREHART FUNERAL HOME		ADDRESS LA PLATA MD	24a. REC'D BY REGISTRAR FEB 6 '58
		24b. REGISTRAR'S SIGNATURE Reberich	

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FEB 6 1973

RECEIVED

FOR STATE
HEALTH DEPT.

Item 18 Film 226

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 01913

1. PLACE OF DEATH a. COUNTY <u>Charles</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WALDORE RURAL</u> c. LENGTH OF STAY IN 1b <u>1</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>CHARLES</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X WALDORE, Md. RURAL</u> d. STREET ADDRESS <u>1 (GALLANT GREEN)</u> e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>GUSTINE</u> Last <u>PENNY</u>		4. DATE OF DEATH Month <u>February</u> Day <u>10</u> Year <u>1950</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 15, 1917</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	11. BIRTHPLACE (State or foreign country) <u>Md.</u>
13. FATHER'S NAME <u>Gustine Penny</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Proctor</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>no</u>	17. INFORMANT <u>Elsie Penny Waldorf, Md.</u> Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute alcoholism with aspiration of vomitus and mucopurulent pharyngeal secretions with acute obstructive emphysema and asphyxia</u> DUE TO (b) <u>obstructive emphysema and asphyxia</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>RS Fisher</u>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Russell S. Fisher, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-12-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St Mary's Cem.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Hunt Funeral Home</u>		22d. LOCATION (City, town, or county) (State) <u>Bryantown, Md.</u>	
24a. REC'D BY REGISTRAR <u>FEB 13 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Redeuch</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the funeral director. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

01914

Reg. Dist. No.

1921

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Charles</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Charles</u>			
CITY (If outside corporate limits, write RURAL or end give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Tompkinsville</u>				TOWN <u>Tompkinsville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Bruce</u>		(Middle)		(Last) <u>Templeman</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>July 4, 1904</u>	
				9. AGE last birthday <u>53</u> yrs.		10. IF UNDER 1 YEAR: Months <u>2</u> Days <u>17</u> (Year) <u>1958</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Ind</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Walter Templeman</u>				14. MOTHER'S MAIDEN NAME <u>Florence ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-30-7907</u>		17. INFORMANT & ADDRESS <u>Florence Templeman Tompkinsville Ind</u>			
18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				19. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2-17-'58</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arterio Sclerotic Disease</u>				1- '53			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not white at work <input type="checkbox"/>		21e. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1-29, 1953</u> , to <u>2-17, 1958</u> , that I last saw the deceased alive on <u>2-6, 1958</u> , and that death occurred at <u>7:45 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>E. L. Plata</u>				ADDRESS (Street, city, town, state) <u>La Plata, Md.</u>		DATE SIGNED <u>2-21-'58</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Buried</u>		DATE THEREOF <u>2-22-58</u>		NAME OF CEMETERY OR CREMATORY <u>Holy Ghost Cemetery</u>		LOCATION (City, town, or county) <u>Tompkinsville Md</u> (State)	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Honett Funeral Home</u>		ADDRESS <u>Waldorf, Md</u>	
DATE <u>Feb 21 1958</u>							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be filled with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

TO ATTENDING PHYSICIAN OR HOSPITAL

TO FUNERAL DIRECTOR: The law requires that the death certificate be filled with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

BUREAU V. S.

FEB 24 1938

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CHARLES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution, residence before admission) a. STATE <u>MARYLAND</u> COUNTY <u>CHARLES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>INDIAN HEAD</u>		c. LENGTH OF STAY IN 1b <u>17 yrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MARY</u> First <u>BEULAH</u> Middle <u>WARDER</u> Last		4. DATE OF DEATH <u>2-16-58</u> Month <u>2</u> Day <u>16</u> Year <u>58</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W-LS</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-23-98</u> 39 yrs.
9. AGE (in years last birthday)		10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE Retd. Gov.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>	10c. BIRTHPLACE (State or foreign country) <u>U.S.</u>
11. CITIZEN OF WHAT COUNTRY?		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Informant</u> Address <u>Manorly, Baldevan</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO <u>Arterio Sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>36 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James F. Anderson</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JAMES F. ANDREXIS</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb 21 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Christ Church</u>		22d. LOCATION (City, town, or county) (State) <u>Urbana, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Funeral Home, Waldorf, Md.</u>		24a. REC'D BY REGISTRAR <u>FEB 21 58</u> DATE	
24b. REGISTRAR'S SIGNATURE <u>Unknown</u>		DATE SIGNED <u>2-17-58</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF NEW YORK
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 2

1938 12 31

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **01916**

1923

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Waldorf</u> c. LENGTH OF STAY IN 1b <u>1 day</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mass</u> b. COUNTY <u>—</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Barre Plains</u> 58x-3 d. STREET ADDRESS <u>North Brookfield Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Ralph</u> Middle <u>T.</u> Last <u>Young</u>			4. DATE OF DEATH Month <u>2</u> Day <u>17</u> Year <u>1958</u>		
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>March 12/97</u>		9. AGE (In years last birthday) <u>60</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Heavy Equipment Operator</u>	
11. BIRTHPLACE (State or foreign country) <u>Mass</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Ralph Young</u>			14. MOTHER'S MAIDEN NAME <u>Ann Clay</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>08-07-7666</u>		17. INFORMANT <u>Mabel Young</u> Address <u>Barre Plains, Mass</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>					INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>years</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>no injury</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>1:30</u> p.m. <u>2-17</u> 1958		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>WALDORF, CHARLES, MD.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>V.B. Dettor</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>V.B. DETTOR</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED <u>17 Feb. 1958</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/21/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Joseph Cemetery</u>	
22d. LOCATION (City, town, or county) <u>BARRE MASS</u> (State) <u>MASS</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>HUNT</u> ADDRESS <u>Waldorf, Md</u>			
24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>		DATE <u>FEB 21 '58</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1968

BUREAU V. 2

FEB 21 1968

RECEIVED